A Communication Intervention for Training Southern European Oncologists to Recognize Psychosocial Morbidity in Cancer. I—Development of the Model and Preliminary Results on Physicians' Satisfaction

LUIGI GRASSI, MD, LUZIA TRAVADO, PHD, FRANCISCO GIL, PHD, RICARDO CAMPOS, MD, PURIFICACION LLUCH, PHD, WALTER BAILE, MD

Abstract—*Background*. The detection of psychosocial distress is a significant communication problem in Southern Europe and other countries. Work in this area is hampered by a lack of data. Because not much is known about training aimed at improving the recognition of psychosocial disorders in cancer patients, we developed a basic course model for medical oncology professionals. *Methods*. A specific educational and experiential model (12 hours divided into 2 modules) involving formal teaching (ie, journal articles, large-group presentations), practice in small groups (ie, small-group exercises and role playing), and discussion in large groups was developed with the aim of improving the ability of oncologists to detect emotional disturbances in cancer patients (ie, depression, anxiety, and adjustment disorders). *Results*. A total of 30 oncologists from 3 Southern European countries (Italy, Portugal, and Spain) participated in the workshop. The training course was well accepted by most participants who expressed general satisfaction and a positive subjective perception of the utility of the course for clinical practice. Of the total participants, 28 physicians (93.3%) thought that had they been exposed to this material sooner, they would have incorporated the techniques received in the workshop into their practices; 2 participants stated they would likely have done so. Half of the doctors (n = 15) believed that their clinical communication techniques were improved by participating in the workshop, and the remaining half thought that their abilities to communicate with cancer patients had improved. *Conclusions*. This model is a feasible approach for oncologists and is easily applicable to various oncology settings. Further studies will demonstrate the effectiveness of this method for improving oncologists skills in recognizing emotional disorders in their patients with cancer. ***J Cancer Educ.*** 2005; 20:79-84

Received from the Section of Psychiatry, Department of Behavior and Communication, University of Ferrara (LG), Clinical Psychology Unit, Centro Hospitalar de Lisboa (zona central) and Faculty of Psychology, Independent University, Lisbon, Portugal (LT), Psycho-Oncology Unit, Hospital Duran i Reynals, Catalan Institute of Oncology, L'Hospitalet, Barcelona, Spain (FG), Section of Psychiatry, Department of Medicine, Psychiatry and Dermatology, University Hospital, University of Zaragoza, Spain (RC); Psycho-Oncology Unit, Hospital Trueta, Oncology Catalan Institute, Girona, Spain (PL); Section of Psychiatry, Department of Neuro-Oncology, M. D. Anderson Cancer Center, University of Texas, Houston (WB).

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Address correspondence and reprint requests to: Luigi Grassi, MD, Clinica Psichiatrica, Università di Ferrara, Corso Giovecca 203, 44100 Ferrara, Italy; phone: +39 0532 236809; fax: +39 0532 212240; e-mail: <luigi.grassi@unife.it>.

Communicating with cancer patients and their families is a core clinical skill in oncology.[1,2] The efficacy of several teaching models in improving the ability of oncologists to respond to their patients' psychological needs, express empathy, and provide emotional support has been shown by several studies.[3-8]

There are, however, a paucity of data showing the efficacy of such courses/workshops for improving the recognition of psychosocial disorders in cancer patients. This is an important deficit in view of the fact that 40% to 50% of cancer patients have been found to meet the criteria for arriving at a psychiatric diagnosis, particularly depression and anxiety.[9,10] Importantly, it has been shown that psychosocial morbidity can increase the patients' length of stay in the hospital,[11] promulgate maladaptive coping mechanisms,[12] reduce quality of life[13] and adherence to treatment,[14] possibly result in a poor response to primary chemotherapy,[15] and

exacerbate the risk of a cancer recurrence.[16] Last, and perhaps most significantly, oncologists tend to misclassify their patients' psychopathological symptoms,[17-19] resulting in an inadequate number of and inappropriate referrals to psycho-oncology services.[20]

A second important issue is that assessment and recognition of psychosocial morbidity in patients with cancer is completely lacking in the Mediterranean region. Scarce communication with cancer patients, collusion with family members, and paternalistic attitudes have been traditionally the most significant problems in these countries, with negative influences on the possibility that patients' concerns can be elicited and addressed.[21-25]

The Southern European Psycho-Oncology Study (SEPOS) was established to address the need to expand the psychosocial dimensions of cancer care in a Mediterranean setting. In summary, the aims of the project were to examine the psychosocial sequelae of cancer and to determine the recognition of these events by oncologists (phase 1, reported elsewhere[26,27]), to develop and apply a training model to improve the ability of oncologists to detect psychological disorders in their patients (phase 2 and the subject of this article), and to evaluate the efficacy of the training approach by reassessing in the same physicians the extent of recognition of their patients' psychosocial problems (phase 3, to be reported in a subsequent paper).

METHODS

This phase 2 project spanned a period of 2 years (2001-2002) and took place in the hospitals of the 3 centers participating in the study, namely, Ferrara, Italy (S. Anna Hospital), Barcelona, Spain (Hospital Duran i Reynals, Catalan Institute of Oncology in), and Lisbon, Portugal (Hospital S. José in). The study was approved by the ethics committees and/or related review boards of each hospital. The principal investigators of each country (LG, LT, FG) met with 1 of the authors (WB) for a 4-day intensive "Setting-up the training and training the trainers" workshop in Ferrara, Italy (October 2001; Trainer Workshop). A second 4-day meeting was organized in Barcelona, Spain to define the material and ultimately the structure of the subsequent dissemination workshops (March 2002).

Then, a 2-day dissemination workshop (6 hours per day) was organized in the local hospitals of the 3 participating centers. The principal investigators who took part in the "Setting up the training and training the trainers" workshop were the facilitators for the 2-day courses, and the oncologists who took part in the overall project (2002) were the participants/learners.

Training Model

The conceptual framework for the workshop involved the following 3 types of learning activities: didactic (eg, slide presentations in large group), interactive (eg, discussion of physicians' opinions derived from their own experiences and video-clips stimuli), and experiential (eg, role playing). The course was organized so that didactic sessions were always followed by interactive sessions and by experiential sessions. Reinforcement of desired behaviors and positive feedback were regularly provided throughout the workshop to strengthen the skills the doctors were learning.

At least 1 week before each of the dissemination workshops, a series of papers published in cancer journals and examining key psychosocial consequences of cancer and the role of communication skills workshops were sent via mail to the oncologists[1,28-30] (preparation phase of the workshop).

The 12 hour dissemination workshop was organized within the hospital of the respective centers in a room that was arranged so that participants were seated in a U shape to maximize interpersonal interactions and facilitate the accessibility of the presentations and formal didactics given during the workshop. The dissemination workshop was divided into 2 sessions presented on 2 separate days. The first session (Module 1) dealt with basic communication techniques and the assessment of patients' emotions. One week later, the second session (Module 2) dealt with assessing psychological distress, anxiety, and depression. Each module used the same order of events: specifically, overview presentations, demonstration, exercises in small groups, role playing, discussion in large groups (Table 1).

1. Overview presentations: Large-group presentations consisted of a series of slides showing data from the SEPOS project. In Module 1, the most significant problems reported by the participating physicians in communicating about and referring cancer patients to mental health and/or psycho-oncology services were shown. Basic communication skills, methods for eliciting and responding to emotions in cancer patients, the meaning of expressed emotions, and the role of the empathic response during the doctor-patient interaction were also explained according to the SPIKES and CLASS algorithms. As explained elsewhere in more detail,[31] the SPIKES and CLASS models summarize the goals and the ways of communicating with cancer patients. SPIKES is an acronym for the 6 steps of communication (S, getting the SETTING right; P, assessing the patient's PERCEPTION; I, obtaining the patient's INVITATION to communicate the information; K, giving KNOWLEDGE and information to the patient; E, EMPATHISING and EXPLORING the patient's emotions; S, STRATEGY and SUMMARY). Likewise, CLASS is an acronym for the specific skills needed to accomplish the goals of the medical encounter: C (CONTEXT and CONNECTION), L (LISTENING skills), A (ADDRESSING emotions using empathic, validating, and exploratory statements), S (management STRATEGY) and S (SUMMARY).

In Module 2, data from the SEPOS was presented and emphasis was given to the prevalence of psychosocial morbidity and the primary concerns of cancer patients who took part in the study, the continuum between a "normal" psychological reaction and an "abnormal" psychological reaction (ie, core symptoms of depression, anxiety, adjustment

TABLE 1. The Structure of the Workshop

Module 1	Module 2
Basic skills	Assessing psychosocial morbidity
8:30–9:10	8:30–9:10
Introduction of participants	Introduction and bridge with Module 1
Define goals and objectives	Define goals and objectives
Slide show (data driven form the SEPOS* with interaction)	Slide show on affective disorders (anxiety, maladjustment, depression and demoralization)
9:10–9:50	9:10–9: 50
Video demonstration (2 video clips; interactive learning with comments)	Video demonstration (2 Video clips; interactive learning with comments)
9:50–10:10	9:50–10:40
Basic techniques review	How to assess anxiety, maladaptive coping, demoralization, depression
Demonstration with a prepared case (conductor + co-conductor)	Demonstration with a prepared case (conductor + co-conductor)
Comments, distribution of material (checklist)	Comments, distribution of material (semistructured interview)
10:10–10:40	
Exercise of basic skills in Groups of 3 with checklist (prepared cases—material for the interviewee, material for the interviewer—checklist for the observer)	
10:40–11:00	10:40–11:00
Coffee break	Coffee break
Advanced techniques	Psychosocial interview
11:00–11:15	11.00–11:45
Dealing with emotions	Exercise in groups of 3 with 3 cases (maladaptive coping, demoralization, clinical depression; prepared cases—material for the interviewee, material for the interviewer—checklist for the observer)
Slide show and video demonstration (2 video clips)	
11:15–11:30	
Demonstration with prepared case (continuation of the previous case) + comments	
11:30–12:00	
Large-group exercise (overhead sheets with cases and options of most appropriate response)	11:45–12:00
	Discussion in large group
12:00–14:00	12:00–14:00
Role playing (facilitator and volunteers)	Role playing (facilitator and volunteers)
14:00–14:30	14:00–14:30
Feedback and conclusions	Feedback and conclusions
(Prompt cards: basic interview techniques, eliciting concerns, addressing emotions)	(Prompt Card—Assessing psychosocial morbidity)

*SEPOS indicates Southern European Psycho-Oncology Study.

disorders, and maladaptive coping). Each 30-minute presentation was followed by 15 minutes of discussion.

Scenarios were also prepared in the form of video clips. Four of the video clips showed "poor" and "good" doctor communication behaviors while relating with cancer patients (Module 1) and 2 were interviews with patients with adjustment disorder and major depression, respectively (Module 2). Each video was followed by an interactive discussion to elicit physicians' observations on the content of the video (eg, basic communication skills, main symptoms of psychosocial disorders) and to reinforce and summarize what was taught during the slide presentations.

2. Demonstrations: Role playing was introduced and explained to the participants. A simulated case was prepared with the facilitators role playing and eliciting responses, feedback, and suggestions for improving the interview from the participants observing the simulated case study.

3. Exercises in small groups: Exercises for groups of 3 participants were devised. In Module 1, the exercise consisted of a general physician-patient interview with 1 physician conducting the interview, a second physician role playing the part of a patient, and a third observing the interaction and recording the basic communication skills that he observed (eg, eye contact, use of silence, open questions, eliciting problems) on a specific form. The 3 roles (physician, patient, and observer) were rotated among the 3 participants. In Module 2, the exercises in small groups of 3 participants consisted of assessing a patient's psychological status (ie, major depression, adjustment disorder and/or maladaptive coping, normal sadness), again with 1 physician conducting the interview, 1 playing the role of a patient and the third observing the interaction and using a checklist to note the patient symptoms that the interviewer identified.

4. Role playing: The physicians then engaged in active role playing, presenting their own "difficult cases" and re-

ceiving feedback form the small group under the guide of the facilitator.

5. General discussion: At the end of the workshop, the participant physicians engaged in discussion regarding the techniques that were learned and practiced. It ended by asking participants to fill out a 1 through 5 Likert evaluation form consisting of 3 parts: the first (6 items) dealt with the usefulness of the training, the second (4 items) regarded the skills of the facilitators, and the third (12 items) assessed the usefulness of each of the individual components of the training model and the likelihood that the methods taught would be used in daily clinical practice. Checklists and prompt cards (eg, main criteria for evaluation of depression, anxiety, maladaptive coping) were provided as tools for future use in the participants' daily hospital practices.

RESULTS

A total of 30 oncologists participated in the workshops (12 in Ferrara, 11 in Barcelona, 7 in Lisbon), of whom13 men (43.3%) and 17 women (56.7%) (mean age = 42.5 ± 8.04; range 29-58). The participants had an average of 15.6 years of practicing medicine (SD = 7.38; range 5-30), and the demographic variables did not differ between countries. The training course was well accepted by most participants (useful = 14 [46.7%], very useful = 16 [53.3%]). The rating by the oncologists showed an appreciation of the training course, and most of the responses were rated as *much/very much*. Details about the results of the questionnaire rating course satisfaction and its evaluation are reported in Tables 2 and 3.

After the course, 28 of the 30 participating physicians (93.3%) believed that had the knowledge garnered from the workshop been available to them, they would have incorporated into their practices the suggestions and methods that they learned during the workshop. Two participants stated they would likely have done so. Half of the physicians (n = 15) strongly believed that their clinical communication techniques improved, whereas the remaining half thought that their communication techniques had likely improved.

DISCUSSION

In this report, we presented the development of a training method to increase the ability of oncologists to elicit their patients' concerns and to recognize symptoms of the major psychosocial problems reported by cancer patients (ie, depression, anxiety, adjustment disorders).

The primary advantage of combining a curriculum-based approach (eg, publications, didactic lectures) with a skill-based approach (eg, practice) was that using both methods re-

TABLE 2. Evaluation of the Workshop

Question	Not at all	A little		Moderately		Much		Very Much	
		No.	%	No.	%	No.	%	No.	%
Have the goals of the workshop been reached?				4	13.3	22	73.3	4	13.3
Has the structure of the workshop been adequate for the objectives?				5	16.7	20	66.7	5	16.7
Has enough time been dedicated to the workshop?		8	26.7	9	30.0	10	33.3	3	10.0
Have the methods used in the workshop been helpful?				1	3.3	23	76.7	6	20.0
Did the cases presented reflect your clinical practice?				7	23.3	14	46.7	9	30.0
Has the workshop been relevant for your clinical practice?				1	3.3	17	56.7	12	40

TABLE 3. Evaluation of the Usefulness of the Single Components of the Workshop

Component	Not at all Useful		A Little Useful		Moderately Useful		Useful		Very Useful	
	No.	%	No.	%	No.	%	No.	%	No.	%
Papers received before the workshop	2	6.7	1	3.3	4	13.3	17	56.7	6	20
Presentation and content of slides					1	3.3	19	63.3	10	33.3
Video material			1	3.3	1	3.3	10	33.3	18	60.0
Demonstration of role-playing	1	3.3			4	13.3	10	33.3	15	50.0
Exercises in groups					2	6.7	8	26.7	20	66.7
Roleplaying										
Using roleplaying					2	6.7	12	40.0	16	53.3
Giving feedback to others			1	3.3	2	6.7	19	69.3		26.7
Receiving feedback from others			1	3.3	1	3.3	13	43.3	15	50
Discussion in large groups					3	10	5	16.7		73.3
General evaluation							14	46.7	16	53.3

inforced the participants' learning experience. Because the formal and didactic aspects of the course were based on cancer literature and on data derived by a project in which the physicians had personally taken part, we believe that their motivation and the attention was elevated during their training.

The training experience was limited by time available for it, which was largely determined by the inability of the participating physicians to leave their clinical practices for 3 to 4 days of intensive training. However, the intent of the workshop was not to teach the entire process of patient-physician communication skills in cancer care (eg, breaking bad news, transition from curative to palliative care, end-of-life issues)[32] but rather to improve physician recognition of the psychosocial problems of their patients and to provide easy guidelines for the appropriate referral of patients who do experience psychosocial difficulties. The structure of the course involving small-group participation offered interactive and practice opportunities that were designed to balance the constraints of time. However, some physicians wanted the course to be longer and believed that an extra module should be developed to explore the course topics in depth. Acting on this suggestion, new modules are being developed to assist future course participants in recognizing, treating, and referring patients demonstrating other psychosocial problems (eg, delirium, dysfunctional family dynamics).

The primary limitation of this study is the sample size. More data are thus needed to fully evaluate the efficacy of single components of the workshop both for reaching the goals set for the workshop and the persistence of the techniques learned during the workshop.[33] Second, larger numbers might permit us to verify possible differences in the reception of the workshop material and the efficacy of the method according to the stage of cancer (ie, assessing depression in patients in different phases of illness) and the context where oncologists work (ie, geographic regions, outpatient vs. inpatient units, hospice).

In summary, the satisfaction reported by the physicians in this preliminary analysis along with the success of the workshop's uncomplicated structure support the notion that basic training models can be implemented and applied in oncology, augmenting an improvement in the quality of the psychosocial care and emotional support given to patients with cancer.

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